

-MEDICARE PRIVACY RELEASE FORM-



Congresswoman
Rosa L. DeLauro

The provisions of state and federal privacy laws require that I receive your written authorization to allow agencies contacted on your behalf to provide me with a reply in response to your request.

Your permission will allow the government departments to comply with the provisions of the privacy acts and insure that your individual rights will not be abused.

Therefore, if you wish me to make any inquiries on your behalf, it is necessary that you complete this authorization and return it to my office.

I, _____, understand that the privacy laws require my
(Print Name Above)

written authorization in order that **Congresswoman Rosa L. DeLauro** can make the appropriate inquiries on my behalf. This signed statement provides my consent to allow her access, on my behalf, to my records.

Signature

Date

Address: _____

City: _____ **State:** _____ **Zip:** _____

Telephone: _____

Social Security Number: _____ **Date of Birth:** _____

Medicare Card Number: _____

Medicare Part D Plan Name: _____

Medicare Part D Plan ID Number: _____

Please designate a contact person for your case (ie. yourself, a relative, an attorney, etc.):

Name: _____ **Relationship:** _____ **Phone:** _____

Address: _____

Return To:

Office of Congresswoman Rosa L. DeLauro

59 Elm Street

New Haven, Connecticut 06510

Phone: (203) 562-3718 **Fax:** (203) 772-2260